

1
FOR STATE
HEALTH DEPT.

2
2 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

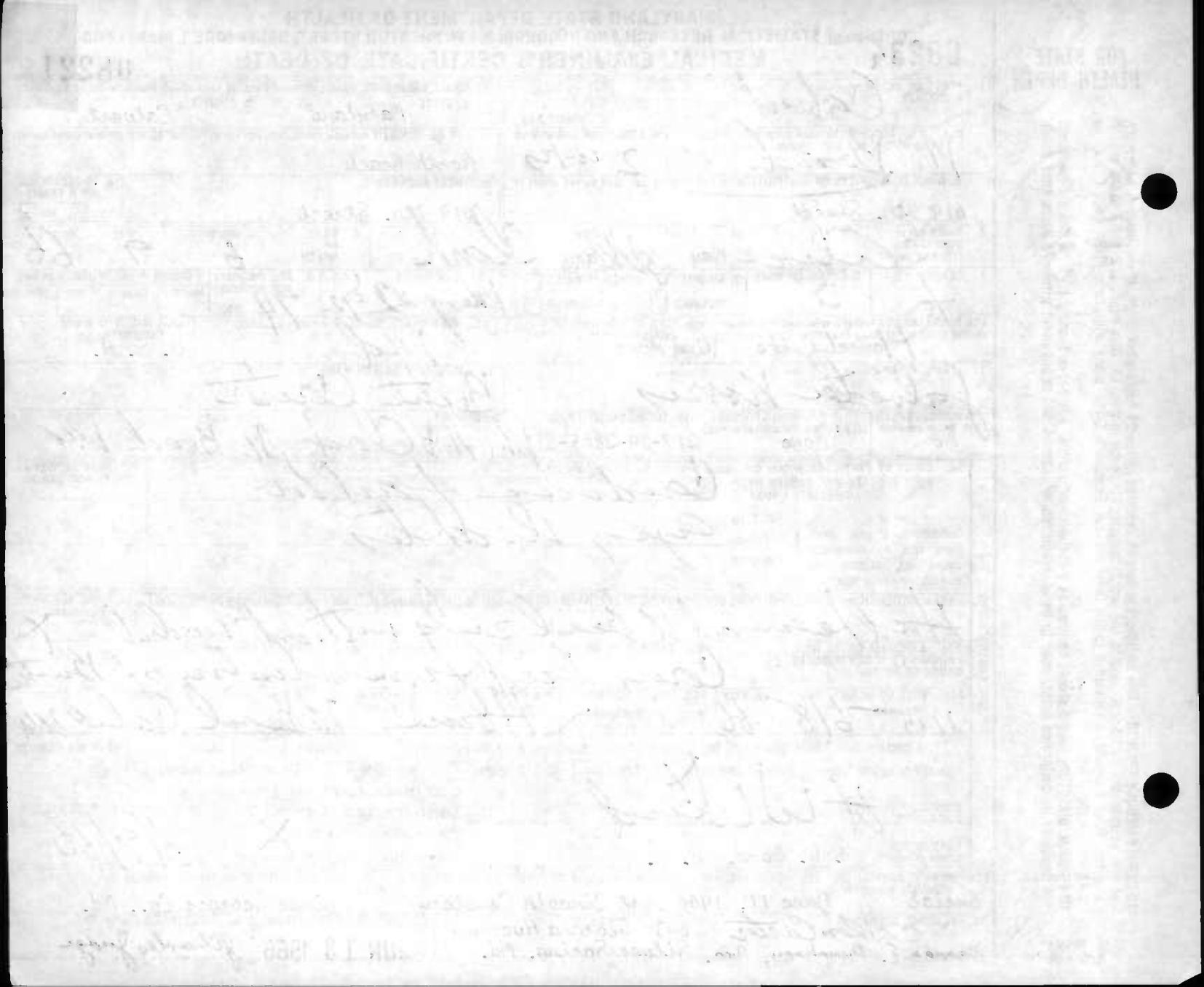
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08234 118221

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>N. Beach</i>		c. LENGTH OF STAY IN 1b <i>2 wks</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>619 7th. Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Alvise</i>		First <i>May</i>	Middle <i>W</i>
4. DATE OF DEATH <i>6 9 1966</i>		Last <i>Clark</i>	Month <i>6</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 22 1922</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <i>Housewife</i>		9. AGE (In years last birthday) <i>74 yrs.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>Calvin Morris</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
14. MOTHER'S MAIDEN NAME <i>Beetie Carter</i>		15. ADDRESS <i>Mr. H B Clark, N. Beach Md</i>	
16. SOCIAL SECURITY NO. <i>217-09-2885-B</i>		17. INFORMANT <i>Cardinal Taylor</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>age, diabetes</i> DUE TO (c) <i>cardiac failure</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had been at N. Beach 2 wks without medical care</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) <i>Carried from shopping to N. Beach</i>	
20c. TIME OF INJURY Month, Day, Year Hour _____ p.m. <i>6/18/66</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>N. Beach</i>		(County) <i>Calvert</i>	
(State) <i>Md</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED <i>6/19/66</i>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward, M. D.</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <i>Prince Georges Co., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 11, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Prince Georges Co., Md.</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i>		24. ADDRESS <i>8434 Georgia Avenue</i>	
24. ADDRESS <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>JUN 13 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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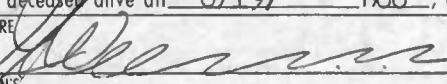
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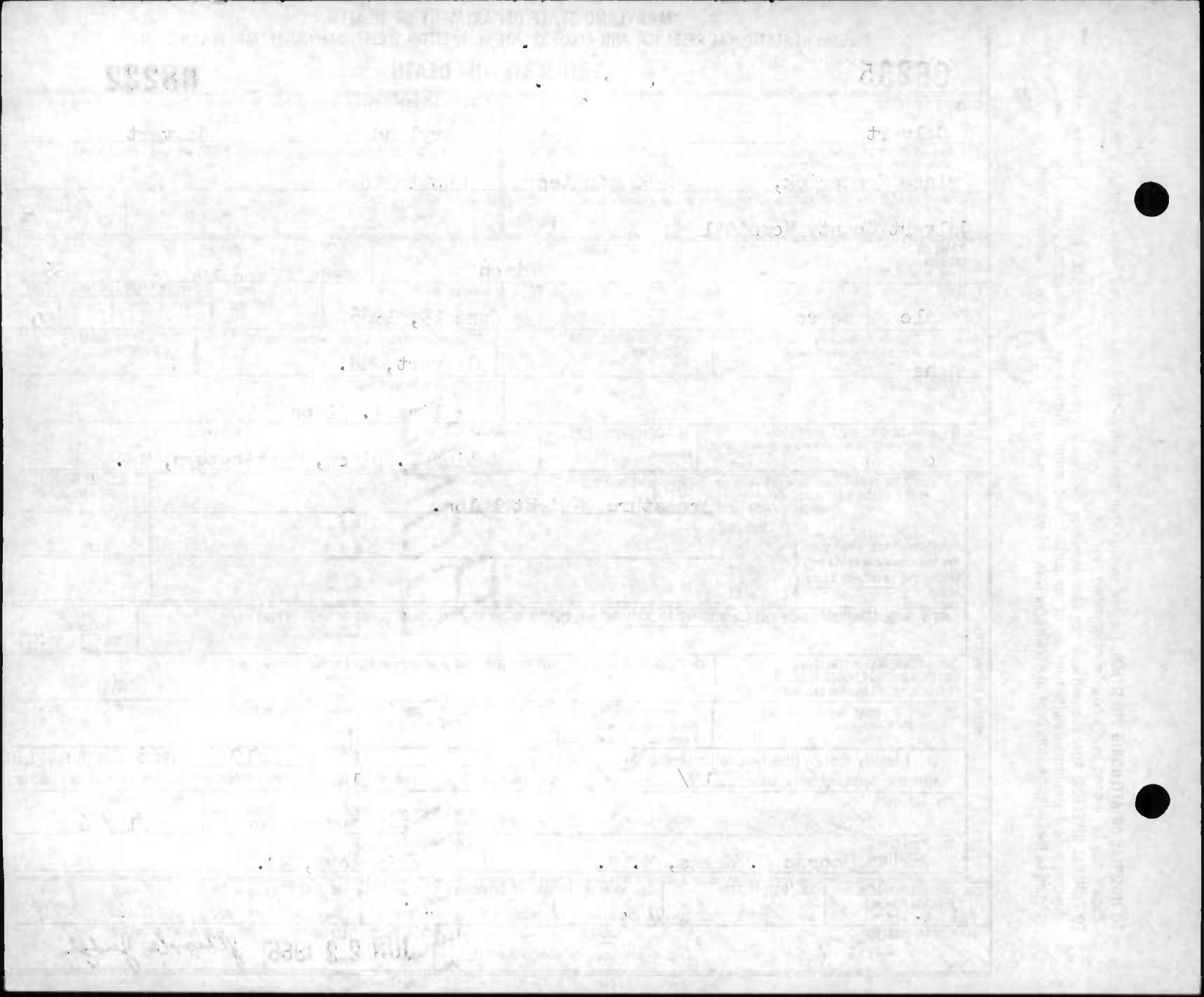
VR A15 (4)
20 M 1/66

08235

CERTIFICATE OF DEATH

08222

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick,		c. LENGTH OF STAY IN 1b 50 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntington		d. STREET ADDRESS 04-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Female		First Dixon	Middle 	Last 	4. DATE OF DEATH June 19	Month 1966	Doy 50
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED	NEVER MARRIED 	<input checked="" type="checkbox"/>	B. DATE OF BIRTH June 19, 1966	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Calvert, Md.		IF UNDER 24 HRS. Days 	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? USA		Hours 	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
				Melina V. Dixon		Melina V. Dixon, Huntington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Weight 1¹/₂ lbs. INTERVAL BETWEEN ONSET AND DEATH 776 X							
DUE TO (b) _____ DUE TO (c) _____							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. {							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/19 , 1966, to 6/19 , 1966, that (I) (we) last saw the deceased alive on 6/19 , 1966, and that death occurred at Huntington , Md., from causes and on the date stated above.							
22a. SIGNATURE 		22b. DATE SIGNED 6/19/66					
22c. PHYSICIAN'S NAME (Type) George J. Weems, M.D.		22d. ADDRESS Huntington, Md.					
23a. BURIAL/CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 6-20-66		23c. NAME OF CEMETERY OR CREMATORIAL Blum Point Church		23d. LOCATION (City or Town) Huntington Cal. Md.	
24. FUNERAL DIRECTOR LeRoy E. Berry Huntington		ADDRESS 		25a. REC'D BY REGISTRAR M.D. JUN 22 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08236

CERTIFICATE OF DEATH

08223

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md. 6 days		c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ernest	Middle Edward	Last Hawkins
4. DATE OF DEATH	Month 6	Day 14	Year 1966
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 31 1883
9. AGE (In years last birthday) 83 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Hawkins	14. MOTHER'S MAIDEN NAME Sue Giles		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO. 215-54-5094	17. INFORMANT Rosie M. Watkins	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X <i>Uremia</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Hypertensive CVP Disease (c) <i>Uremia</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 101
20f. (City or town) Huntingtown (County) Md. (State) Maryland		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 10/1/1945 to 6/14/1966 , that (I) (we) last saw the deceased alive on 6/14/1966 , and that death occurred on 6/14/1966 from causes and on the date stated above.			
22a. SIGNATURE <i>George Weems</i>		22b. DATE SIGNED 6/14/66	
22c. PHYSICIAN'S NAME (Type) Dr. George Weems		22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 6-18-66		23b. DATE THEREOF 6-18-66	
23c. NAME OF CEMETERY OR CREMATORIALy		23d. LOCATION (City or Town) (County) (State) Dunkirk Cal. Md.	
23e. COopers Ch. Cem.		23f. REGD. BY REGISTRAR Charles Judge	
24. FUNERAL DIRECTOR Linkney E. Sewell <i>Prince Frederick</i>		25a. REGISTRAR'S SIGNATURE Charles Judge	

229-21

68360

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08237 118224

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution/Residence before admission) a. STATE b. COUNTY	
<i>Calvert</i> MARYLAND		<i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <i>Prince Frederick 40 min</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Colonial Cott</i>		d. STREET ADDRESS <i>407 72nd Place</i>	
3. NAME OF DECEASED (Type or print)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First <i>Wilton</i>		Middle <i>Caesar</i>	
Last <i>Henry</i>		4. DATE OF DEATH Month Day Year <i>6 11 1966</i>	
5. SEX <i>M</i>		5. COLOR OR RACE <i>W</i>	
6. MARRIED WIDOWED <i>W</i>		7. NEVER MARRIED DIVORCED <i>W</i>	
8. DATE OF BIRTH <i>8/24/48</i>		9. AGE (In years last birthday) yrs. <i>71/8</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>Floyd Henry Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Norma Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFDRMAN <i>Floyd Henry Jr.</i>		407 72nd Place Address <i>Carmody Hills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>82334</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral pressure</i>	
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>Fractured skull, lacer</i>			
DUE TO (c) <i>Auto accident</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>Crushed Chest</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Auto ran into bank</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>3 pm. 6 11 66</i>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5th Street N. Beach Calvert 40</i>	
20e. (City or town) <i>Wilmington</i>		(State) <i>N. C.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <i>6/11/66</i>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23b. DATE THEREOF <i>XXX 6-13-66</i>		Address (Street, city, town, or county) <i>5801 Cleveland Ave</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Peace Memorial</i>		23d. LOCATION (City, town or county) <i>Wilmington, N. C.</i>	
24. FUNERAL DIRECTOR <i>W. W. Chambers Co.</i>		25a. REC'D BY REGISTRAR <i>JUN 14 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

This is a high-contrast, overexposed image of a handwritten document. The text is mostly illegible due to the lighting, but some words and numbers can be discerned. The document appears to be a list of items, possibly a ledger or a list of goods. The handwriting is cursive and fluid. The paper shows signs of age and wear, including creases and discoloration. The background is a light, textured surface, likely a wall or a piece of paper.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

4. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. PLACE OF DEATH o. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict	
3. NAME OF DECEASED (Type or print) Charles Eric Higgs		d. STREET ADDRESS	
4. DATE OF DEATH June 1 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED WIDOWED		8. DATE OF BIRTH 6/22/85	
9. AGE (In years lost birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allie Higgs		14. MOTHER'S MAIDEN NAME Mary Farrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 213-22-0137	
17. INFORMANT Mrs. Lillie Lee Higgs, Benedict, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Cerebral Cerebral edema Generalized arthrosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to Jun 1966, that (I) (we) lost saw the deceased alive on 1966, and that death occurred at M, from causes and on the date stated above.		22b. DATE SIGNED 6-1-66	
22c. PHYSICIAN'S NAME (Type) Roberto deVillarreal		22d. ADDRESS St. Leonard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-6-66	
23c. NAME OF CEMETERY OR CREMATORIAL ST MARY'S CEM.		23d. LOCATION (City or Town) (County) (State) BRYANTOWN MD.	
24. FUNERAL DIRECTOR The Hunter Funeral Home, Waldorf, MD.		ADDRESS	
		25a. RECEIVED BY REGISTRAR JUN 10 1966	
		25b. REGISTRAR'S SIGNATURE James J. Judge	

2
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.				c. LENGTH OF STAY IN 1B 2 days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Female				6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/9/92		9. AGE (in years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic				11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Vaught				14. MOTHER'S MAIDEN NAME Josephine Smith									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No				16. SOCIAL SECURITY NO. 227-10-6102				17. INFORMANT Mrs. Elmer Deane				Address Box 337 Chesapeake Beach, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension CVR disease</i> 442X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis -</i> (c) <i></i>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Huntingtown, Md.		(County) Huntingtown, Md.		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from <i>7/10</i> , 1966, to <i>6/3</i> , 1966, that (I) (we) last saw the deceased alive on <i>6/3</i> , 1966, and that death occurred at <i>4:35 PM</i> , from the causes and on the date stated above.													
22a. SIGNATURE <i>George J. Weems</i>												22b. DATE SIGNED 6/3/66	
22c. PHYSICIAN'S NAME (Type) Dr. George J. Weems				22d. ADDRESS Huntingtown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF June 6, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Goodwins Ferry Cemetery		23d. LOCATION (City, town or county) Near Radford, Giles Co. Va.				(State)	
24. FUNERAL DIRECTOR <i>Hutchins Funeral Home</i>				ADDRESS Owings, Maryland		25a. REC'D BY REGISTRAR JUN 9 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

1
FOR STATE
HEALTH DEPT.

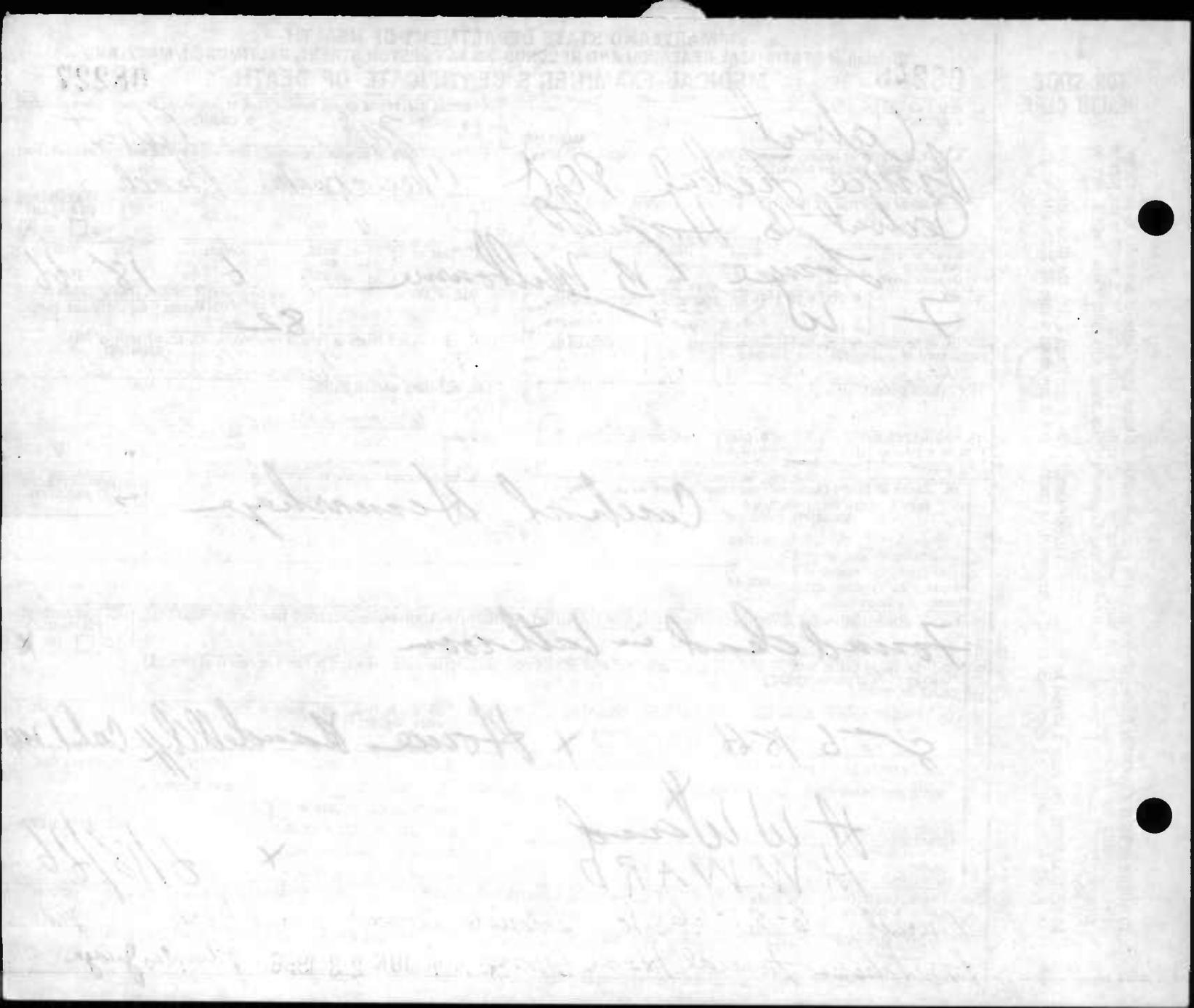
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08240		118227	
<p>1. PLACE OF DEATH a. COUNTY <i>Calvert</i></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i></p> <p>c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Calvert Co Hospital</i></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chesapeake Beach</i></p> <p>d. STREET ADDRESS <i>04-1</i></p>	
<p>3. NAME OF DECEASED (Type or print) <i>Louise</i></p> <p>First <i>L</i> Middle <i>M</i> Last <i>Wilbourne</i></p>		<p>4. DATE OF DEATH Month <i>6</i> Day <i>18</i> Year <i>1966</i></p>	
<p>5. SEX <i>W</i></p>		<p>6. COLOR OR RACE <i>W</i></p>	
<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i></p>	
<p>13. FATHER'S NAME <i>Believe</i></p>		<p>11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i></p>		<p>16. SOCIAL SECURITY NO. <i>1</i></p>	
<p>17. INFORMANT <i>Unknown</i></p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i></p>	
<p>Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>331X</i></p>		<p>DUE TO DUE TO</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour <i>6</i> p.m. <i>18 1966</i></p>		<p>20d. INJURY OCCURRED <i>White</i> Not White <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work</p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>Home</i></p>		<p>20f. (City or town) <i>Baltimore</i> (County) <i>Calvert</i> (State) <i>Md</i></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>		<p>22. DATE SIGNED <i>6/18/66</i></p>	
<p>ACTUAL SIGNATURE <i>H. W. Ward</i></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>EXAMINER'S NAME (Type) <i>H. W. WARD</i></p>		<p>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i></p>		<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>	
<p>23b. DATE THEREOF <i>6-21-66</i></p>		<p>Address (Street, city, town, or county) <i>So Memorials Garden</i></p>	
<p>23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>6-21-66</i></p>		<p>23d. LOCATION (City, town or county) <i>Herrick</i> (State) <i>Md</i></p>	
<p>24. FUNERAL DIRECTOR <i>Hitchins Funeral Home Owings Mills</i></p>		<p>25a. REC'D BY REGISTRAR <i>JUN 23 1956</i></p>	
<p>25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i></p>			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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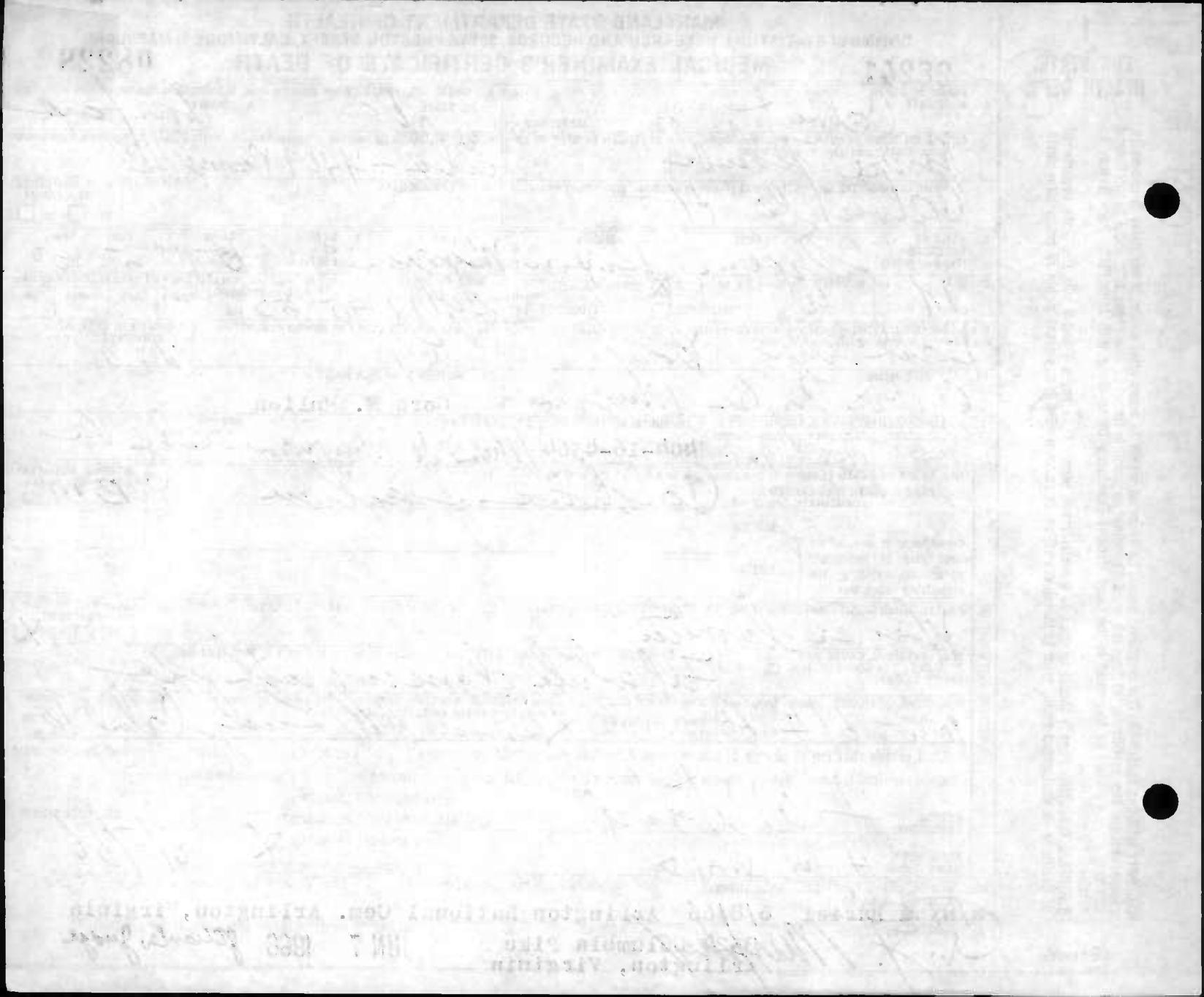
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18228

08241

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Va</i> b. COUNTY <i>Fairfax</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brice residence</i>		c. LENGTH OF STAY IN 1b <i>Calvert Co</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alex - 4409 Round Hill</i>	
d. STREET ADDRESS <i>83-3</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Spencer Dixie Muzzane</i>		First <i>S</i>	Middle <i>p</i>
4. DATE OF DEATH <i>6 June 1966</i>	Month <i>6</i>	Day <i>June</i>	Year <i>1966</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 17 1915</i>
9. AGE (in years last birthday) <i>50</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Bank teller</i>	11. BIRTHPLACE (State or foreign country) <i>Ky</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Orbie Taylor Muzzane</i>	14. MOTHER'S MAIDEN NAME <i>Cora E. Mullen</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> 16. SOCIAL SECURITY NO. <i>404-16-4564</i> 17. INFORMANT <i>Spouse of deceased by Va</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> (c)		Address <i>Constance of Calvert Co</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Was a diabetic</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Fell while dancing with wife</i>	20b. DESCRIBE HOW HURRY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>While</i>	20c. TIME OF INJURY Month, Day, Year Hour <i>am</i> 20d. INJURY OCCURRED at work <input type="checkbox"/> Not While <input type="checkbox"/> P.M. <i>6/4/66</i> at work <input type="checkbox"/> <i>While</i>	20e. PLACE OF INJURY (Home, farm, etc.) 20f. (City or town) <i>House 4000 Columbia Pike</i>
20g. (County) <i>Calvert Co</i>	20h. (State) <i>Virginia</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>Address (Street, city, town, or county)</i>	
EXAMINER'S NAME (Type) <i>H. W. WARD</i>		22. DATE SIGNED <i>8/5/66</i>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <i>Burial 6/8/66</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National Cem. Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>R. J. Murphy</i>		25a. ADDRESS <i>3520 Columbia Pike</i>	25b. REC'D BY REGISTRAR <i>JUN 7 1966</i>
		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 M

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ~~exhibited~~ within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

CERTIFICATE OF DEATH						08229		
1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Calvert</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PRINCE FREDERICK</i>		c. LENGTH OF STAY IN 1b <i>Calvert Co Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lusby, Md.</i>		d. STREET ADDRESS <i>04-1</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co Hospital</i>			d. STREET ADDRESS <i>Lusby, Md.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>EVELYN</i>	Middle <i>I</i>	Lost <i>POLK</i>	4. DATE OF DEATH <i>6 22 1966</i>	Month <i>6</i>	Day <i>22</i>	Year <i>1966</i>
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-1-12</i>	9. AGE (In years lost birthday) <i>54</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Calvert</i> Md.		
13. FATHER'S NAME <i>James Smith</i>			14. MOTHER'S MAIDEN NAME <i>Annie</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-16-2865</i>		17. INFORMANT <i>James H. Polk- Lusby, Md.</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause</u> lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>Hour</i> <i>Failure</i> <i>Second</i> <i>Diabetes.</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>1962</i> , 19, to <i>1966</i> , 19, that (I) (we) last saw the deceased alive on <i>6-22</i> , 1966, and that death occurred at <i>S.P. M.</i> , from causes and on the date stated above.						22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <i>ISSAM F. Damalouji</i>						22d. ADDRESS <i>Prince Frederick, Md. 20678</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-25-66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Johns Church Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Lusby, Calvert Md.</i>		
24. FUNERAL DIRECTOR <i>Leroy Berry</i>		ADDRESS <i>Huntington, Md.</i>		25a. RECD. BY REGISTRAR DATE <i>JUN 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08243

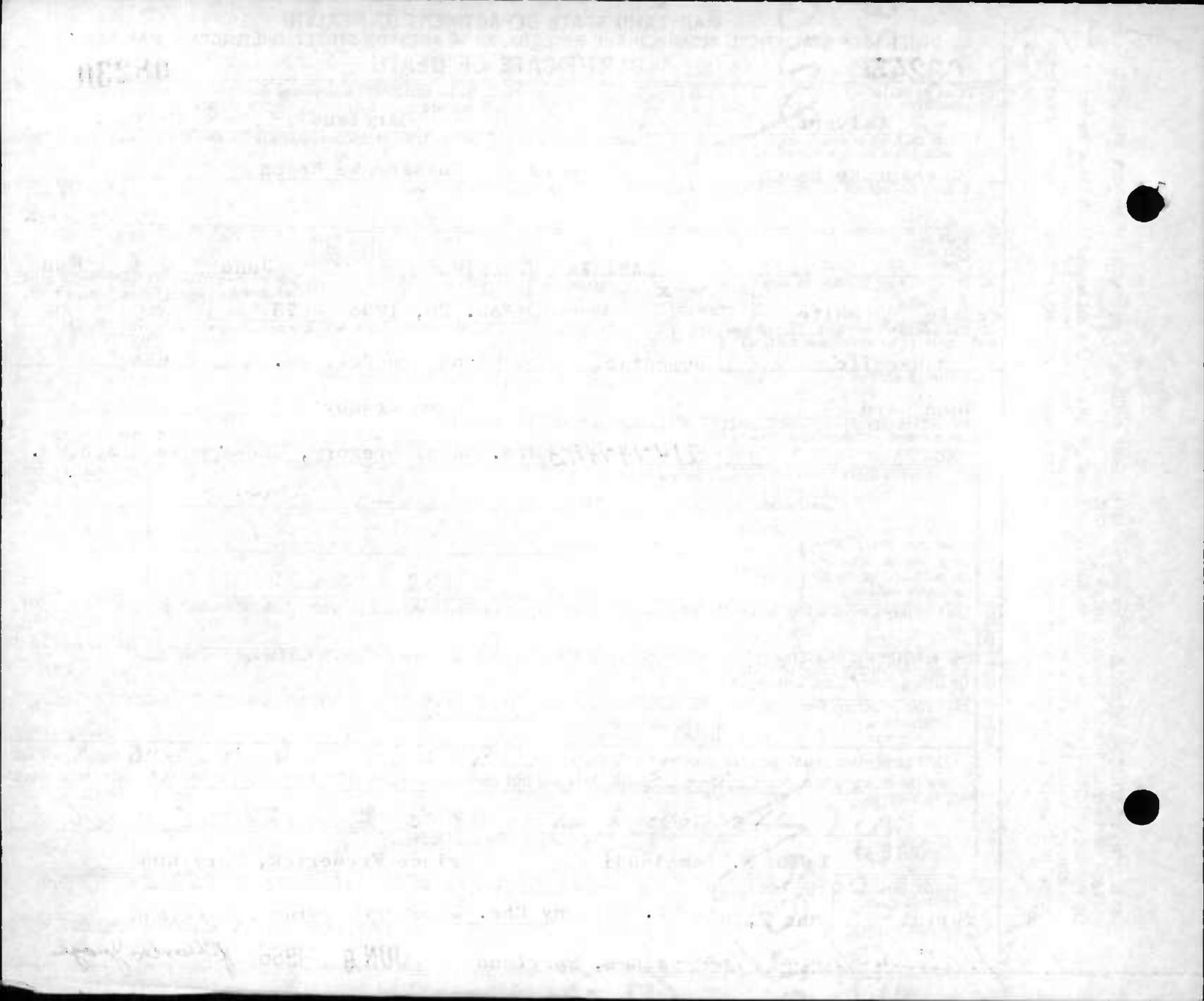
CERTIFICATE OF DEATH

08230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Calvert MARYLAND		Maryland b. COUNTY Calvert	
b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Chesapeake Beach 43 years		d. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Chesapeake Beach 04-1	
00		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
MOLLIE		LAVINIA	STALLINGS
4. DATE OF DEATH		Month	Day Year
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		white	WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Feb. 20, 1893		73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Domestic	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Anne Arundel, Md.		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John Ward		Laura Croshy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		Address	
		Box 83 Mrs. Mabel Gregory, Chesapeake Beach, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
4500 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		- Failure -	
DUE TO (b)			
DUE TO (c)		Mass - Lebi Chest.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962, 19, to 6-4-, 1966 that (I) (we) last saw the deceased alive on 6-3-1966, and that death occurred at 11:20 AM, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 6/5/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Issam F. Damalouji		Prince Frederick, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORY	
June 7, 1966		Mt. Harmony Chr. Cemetery	
24. FUNERAL DIRECTOR		23d. LOCATION (City, town or county) (State)	
Hutchinson Funeral Home		Owings, Maryland	
Owings, Maryland		25a. REC'D BY REGISTRAR	
		25b. REGISTRAR'S SIGNATURE	
		DATE JUN 9 1966 g Charles Judge	



FOR STATE
HEALTH DEPT.

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10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08231

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co. H</i>		d. STREET ADDRESS <i>5705 - Branch Ave., SE</i>	
3. NAME OF DECEASED (Type or print) <i>LAST NAME</i> <i>Tolson</i>		4. DATE OF DEATH <i>James</i> Month <i>July</i> Day <i>18</i> Year <i>1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26-1897</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - U.S. Gov.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Treasury Dept.</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, DC</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Oliver Tolson</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Clark</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>16. SOCIAL SECURITY NO.</i>	
17. INFORMANT <i>Mrs. Alma L. Tolson (Wife)</i>		Address <i>Same as #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Cardiac failure</i> <i>Cardiovascular reversal during</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>2</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Lead a car at 107 at 11:00</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>a.m.</i> <i>6</i> <i>11</i> <i>66</i> p.m. <i>1966</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <i>at work</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>(City or town) (County) (State)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>6/11/66</i>			
22. DATE SIGNED <i>6/11/66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>June 14-1966</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>Simmons Bros.</i>		25a. REC'D BY REGISTRAR DATE <i>JUN 14 1966</i>	
ADDRESS <i>1661- Gd. Hope Rd. SE. Wash., DC</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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1828 STATION 294443 MASS